Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Grange Medical Practice, Cardiff and Vale University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Grange Medical Practice, Cardiff and Vale University Health Board on 16 January 2023.

Our team for the inspection comprised of one HIW Healthcare Inspector and three clinical peer reviewers. The inspection was led by a HIW Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found that staff at Grange Medical Practice were committed to offering a caring and friendly service to patients.

We witnessed staff treating patients in a kind and professional manner and we observed effective arrangements in place to protect the privacy and dignity of patients.

This is what we recommend the service can improve:

- Staff must ensure they are providing the Active Offer for Welsh speaking patients
- Staff should make every effort to ensure patients' preferred language is recorded consistently across patient records.

This is what the service did well:

- It was clear that Grange Medical Practice works hard to accommodate the many languages spoken by their diverse patient population
- The practice was situated in a very spacious building. Automatic and wide doors on the entrance allowed for access for patients in wheelchairs and motorised scooters.

Delivery of Safe and Effective Care

Overall summary:
We were assured that patients attending Grange Medical Practice received safe and effective care. All clinical rooms were an appropriate size and generally kept tidy.

We reviewed the business continuity plan. This contained all relevant and up to date information, in line with local health board procedures, however we highlighted improvements around ensuring this document is regularly reviewed.

Immediate assurances:

- Staff must ensure that checks on emergency drugs and equipment are completed and always logged, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged. All emergency drugs must also be stored securely.

This is what we recommend the service can improve:

- Data shredding stored in clinic rooms and storage rooms currently pose a fire risk. Staff must ensure that bags of shredding are stored securely in outdoor bin area
- The practice should carry out Infection Prevention Control, hand hygiene and clinical waste audits as soon as possible
- Staff must ensure the safeguarding policy is updated to include details of the current Safeguarding lead at the practice and contains information specific to Wales.

This is what the service did well:

- We observed the practice to be generally tidy and uncluttered.

Quality of Management and Leadership

Overall summary:
From discussions with practice staff, it was clear that they were committed to providing good patient care and were eager to carry out their roles effectively.

We saw diary markers on staff computers indicating space for weekly team meetings, however, the practice should produce meeting minutes.

Immediate assurances:

- The practice must ensure that pre-employment checks for all staff include a DBS check appropriate to their roles. All current members of staff must have a DBS check undertaken urgently. A record must be kept within the practice
- The practice must ensure all staff complete and remain up to date with all mandatory training and record evidence of this in staff files. The practice manager must also develop a training matrix to effectively keep track of mandatory staff training
- The practice manager must ensure that all clinical staff have received the Hepatitis B vaccination and evidence of this is recorded in their staff files.

This is what we recommend the service can improve:

- The practice should update all practice policies, ensuring they are dated and contain a date for annual review.
- We also recommended that the practice manager implement a sign and date sheet for policies, so staff can sign and date once read
- All staff must complete equality, diversity, and inclusion training as soon as possible. Evidence of completed training should be recorded in staff files by the practice manager.

This is what the service did well:

- It was clear from conversations with the practice manager that the practice is proactive in the cluster group in developing future plans.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. We received two completed questionnaires.

Staying Healthy

Health Protection and Improvement
On the day of our visit, we found that there was a range of health promotion information and advice available for patients. Posters from Public Health Wales were displayed on the walls and TV screens in the waiting area. The practice manager also confirmed that these are updated whenever they receive new information.

We also spoke to the practice manager about how other health initiatives are supported and promoted within the practice. They told us that a midwife is based at the practice twice a week and offers face to face appointments, as well as signposting advice to other services, such as breastfeeding groups. We were informed that there is also a physiotherapist who works on site that patients can book in with directly.

The practice manager told us that they no longer have an in-house counsellor as this service was removed during the COVID-19 pandemic. However, there is now a mental health liaison worker operating across the cluster, who was describing as having an extensive knowledge of services to signpost to. Patients can book in with this individual to get referred to the relevant service.

The practice had a robust follow up process with parents or guardians for children who don't attend appointments. In such instances a letter will be sent to the parents or guardians and the practice will inform the health board of any concerns. The practice manager also told us that they contact families via telephone to follow up and monitor the situation.

Dignified care

Communicating effectively

During our tour of the setting, consultation and treatment rooms were situated away from the waiting area. Clinic room doors were always kept closed during appointments and all contained curtains to preserve patient dignity during examinations.

The reception desk was situated in the spacious ground floor waiting area. No telephone calls were taken at the reception, but in the office situated away from the reception area, ensuring no conversations could be heard by patients in the waiting area. Staff also informed us that any patients wishing to speak to a staff member in private could use a room next to the reception desk.

It was clear from our discussions with staff that the practice works hard to try and meet individual patient needs. We were told that there is a hearing loop installed at the practice, and signs informing patients of this. The practice also has access to sign language translators, as well as language line through the local health board.

We saw evidence of a system in place at the practice to offer chaperones to patients who require it. Both male and female chaperones can be provided, and this was clearly advertised in the practice waiting area. There was a chaperone policy in place, and staff informed us that chaperone training is provided in house by the practice GPs.

It was clear from our findings during the inspection that practice staff work hard to accommodate the wide range of languages spoken amongst their diverse patient population. Staff informed us that each patient is asked their preferred language when registering. This is then recorded in their clinical records and a pop-up will appear notifying staff if translation service will be needed for patients when they book appointments. However, this information was not being consistently recorded in clinical records. Staff were informed that we require this to be done consistently and recommended carrying out an audit of the preferred language feature in patient records. This would help determine whether staff have not recorded the information, or if it is the patient who hasn't provided the information.

From our discussions with staff, it was clear that Welsh speaking patients are not currently receiving the active offer when attending the practice. The practice must ensure that the active offer is available to Welsh speaking patients. We also recommended that Welsh speaking staff be provided with 'Iaith Gwaith' badges.

We reviewed practice policies as part of our visit and discovered that there is currently no consent policy or triage policy in place at the setting. Senior staff should develop and implement these policies as soon as possible and ensure they are read by all staff.

Patient information

We viewed the practice website and saw that it provided information for patients. This included practice opening times, lists of staff, and information on how to book flu vaccinations and repeat prescriptions online. The website is also available in many languages which benefits the practice's diverse patient population.

The Putting Things Right complaints process and the practice own complaints procedure were displayed in both waiting areas at the setting. The setting's procedure aligns with the NHS policy and included all relevant information, including the staff member responsible for handling the complaints and the approximate timescales for providing a response.

Timely care

Timely Access

Grange Medical Practice opens between the hours of 8:00am to 6:30pm Monday to Friday. Appointments can be accessed via telephone or by visiting the practice in person, however some nurse appointments could also be booked online. We were told that appointments were released a week in advance and that doctors could book follow up appointments up to four weeks in advance.

According to staff, most patients who wish to book a same day, face to face appointment can access one.

We were informed that the practice has an effective telephone system to allow for booking appointments. It includes a limitless queuing system and patients are informed of their place in the queue whilst waiting.

Both patients that completed the HIW questionnaire, said that they were satisfied with the opening hours of the practice. When asked of their experience in booking an urgent appointment, one patient noted that they 'strongly agree' that they can get same- day urgent appointments. However, the other patient disagreed with this. Both respondents said that their experience of booking a routine appointment was 'good'.

Individual care

Planning care to promote independence

The practice was fully accessible for all patients. The main entrance had automated doors which led into a spacious waiting area. There was a disabled toilet on the ground floor and a lift in operation to access the first floor waiting area.

The practice manager informed us that the practice's patient population is very diverse in regard to nationality and spoken language. We were told that patients can request documents to be produced in alternative languages or in easy- read format. The practice website is also available in a range of languages.

People's rights

Both patients who completed questionnaires told us that staff at the practice treated them with dignity and respect. Throughout the inspection we observed staff greeting patients in a friendly and welcoming manner.

The practice manager informed us of examples where reasonable adjustments are in place to ensure that all patients can access the services they require. They told us that one of their patients has hearing difficulties and can't ring for an appointment. The practice has arranged for this patient to email them to book an appointment.

We were also informed that there are two wheelchairs kept on site, in the event a patient needed assistance entering or leaving the practice. The main doors and corridors in the practice are also wide enough to accommodate wheelchairs and motorised scooters, thus making the practice fully accessible.

From discussions with staff, it was clear that the practice work hard to uphold the rights of transgender patients. We were told that a patient's preferred pronouns are recorded in patients records and the relevant medical treatment would be offered throughout a patients' transition. An example given was that a patient transitioning from female to male would be referred to as male, however if they still had a cervix, would be invited for a smear. Staff told us that they will also prescribe hormone drugs if the patient is going through an NHS program.

Both patients who completed HIW questionnaires indicated that they felt staff listened to them and answered their questions. The respondents also agreed that they were provided with enough information to help them understand their care.

During our visit, the practice manager confirmed that there is currently no equality and diversity policy or discrimination policy in place at the practice. Staff should develop these policies as soon as possible and ensure both are read by all staff.

Listening and learning from feedback

We were provided with evidence of a complaints policy and procedure which was displayed in both waiting rooms at the practice. This complied with the NHS Putting Things Right procedure and provided guidance to patients and their carers should they wish to raise a complaint. The procedure outlined that the practice manager was responsible for managing complaints and we saw evidence that all complaints were kept on file. We reviewed a sample of the complaints received by the practice and noted that an appropriate response was provided within the stated timescale. The practice website also provided information regarding making complaints.

The practice gathered patient feedback via an online survey available on their website. We were told that annual surveys are sent out to all patients, however the practice receives very few responses from this. Patients can also provide feedback via social media and google.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
The practice was located within a purpose-built two storey building. We found that the areas used by patients and staff were generally tidy and uncluttered. We were also provided with the Business Continuity Plan for the practice. The plan contained relevant and up to date information, in line with local health board procedures, however we require the practice manager to ensure the plan is dated and contains a date for annual review.

Staff told us that the practice manager is responsible for receiving patient safety alerts. They are them disseminated to the rest of the team electronically, and a copy is left in the staff room for review. We were informed that all learning from patient safety incidents is shared during weekly staff meetings.

During our tour of the practice, we observed bags of data shredding being stored in clinic rooms and storage rooms, awaiting collection. We felt this posed a significant fire risk and insisted staff ensure that bags of shredding are stored securely in outdoor bin area.

The practice manager informed us that the building owner undertakes both environment and health and safety risk assessments, however copies had not been provided to the practice. The practice must keep copies of these risk assessments on file.

Our inspection highlighted that checks of emergency drugs and equipment were not being carried out in line with Health Board procedure and Resus UK guidance. This poses a patient safety risk due to the potential for equipment to be missing and not immediately available when required in an emergency. We also discovered that emergency drugs were not being stored securely. We raised immediate concerns over this. Staff must ensure that checks are completed and always logged, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged. Staff must also ensure that all emergency drugs must be stored securely.

Infection prevention and control (IPC) and Decontamination

During our tour of the practice, we observed IPC to be managed well at the setting. The patient areas were visibly clean, and all areas had hard flooring. We saw evidence of hand hygiene facilities available for staff and patients. Soap was available in all patient toilets and there was alcohol gel available in communal area. All surgeries had appropriate handwashing facilities in place with elbow operated taps as well as ready access to a supply of personal protective equipment (PPE).

The practice continues to encourage to use of face masks. Signs on use of face masks were placed in communal areas, as well as information regarding the importance of using hand hygiene facilities correctly.

It was evident that the practice had taken effective steps to reduce the risk of the spread of infection. The practice has a separate entrance for suspected respiratory patients. This led into a segregated area, away from all other surgeries and patient waiting areas, thus limited the risk of the infection spreading. Staff told us that full PPE would be worn to treat such patients.

We identified that no infection, prevention and control (IPC), hand hygiene or clinical waste audits had been completed. This was brought to the attention of staff and the practice must ensure that these audits are completed as soon as possible.

We saw evidence of an IPC risk assessment in place at the practice, however this document was out of date. We require staff to review this document and ensure it is kept up to date through annual reviews.

Our review of staff records highlighted that there is currently no evidence of Hepatitis B vaccinations for staff. This was raised with senior staff as an immediate concern. The practice manager must ensure that all clinical staff have received the Hepatitis B vaccination and that evidence of this is recorded in their staff files.

Medicines management

We spoke to senior staff regarding the arrangements in place for ensuring prescription pads are securely stored. They informed us that these are either kept in the rear reception room, away from patient access, or in locked drawers in the doctor's rooms. We saw evidence of an effective audit trail in place to keep track of when and by whom prescriptions are collected. This information is recorded upon collection and all prescriptions were RX coded.

Staff confirmed that, in the event a GP leaves the practice, their prescription pad would be shredded to prevent future use. We were also informed that the GP partners ensure that all RX coding clerks at the practice have received the relevant health board training.

Safeguarding children and safeguarding adults at risk

We saw that the surgery had a safeguarding policy in place, however this contained out of date information regarding the safeguarding lead at the practice and did not contain information specific to Welsh guidance. The safeguarding lead for the surgery was one of the GP partners, however this individual was not listed in the policy. The individual noted was a previous safeguarding lead, thus supporting the issue of the policy being out of date.

We also noted that the practice had an out-of-date copy of the All-Wales Child Protection Procedures, and when speaking to staff, it was clear that there wasn't an up-to-date version available, nor did staff have access to the All Wales Safeguarding mobile phone app. We raised this with staff and gave them information on the phone app and how to access it. We recommended all staff download the app to allow for easy access to up-to-date guidance.

We saw evidence of a process in place at the practice to easily identify children on the children protection register. Flags are placed on records of children on the child protection register and staff told us that these are reviewed at quarterly child protection meetings. However, our discussions with staff indicated a lack of knowledge regarding the process in place to remove flags from patient records, indicating a potential child at risk. We spoke to staff about this and insisted all relevant staff are trained to do this, to ensure records for such children are kept up to date.

We were informed that all clinical staff had completed the relevant level safeguarding training, however at present, non- clinical staff have not. We also saw little evidence in staff files to support that this training had in fact been completed. We raised this as an immediate concern with the setting and insisted that all staff receive the correct level of training and produce evidence that staff have completed the course.

Medical devices, equipment and diagnostic systems

We were told that the practice nurses were responsible for checking and cleaning the medical devices and equipment at the surgery. Nursing staff told us that they check and clean equipment after every use.

Although there was not a contract in place to maintain medical equipment and devices, equipment at the surgery was in a good condition.

During our visit, we noticed that, although yellow clinical bins were kept in secure rooms, the bins themselves were open. We mentioned this to staff and informed staff that all yellow clinical bins should be locked, even whilst in locked rooms.

Effective care

Safe and clinically effective care

Senior staff informed us that they are responsible for keeping up to date with best practice and national and professional guidance. The practice manager also told us that guidelines and examples of best practice are circulated to staff via email and are also printed and left in the staff room to be read on breaks.

We were told that any changes or updates to the National Institute for Health and Care Excellence (NICE) guidelines are discussed in weekly clinical partner meetings. Information is then cascaded to other staff if relevant.

Information governance and communications technology

Staff informed us of the arrangements for data security at the practice. They confirmed the setting had a data protection officer who is appropriately trained. This service is provided by the local health board.

The setting had a clear process in place for the handling of personal and sensitive data. Information on this was available for patients via the practice website and signage in the reception area.

Record keeping

We reviewed a sample of 10 electronic patient medical records. These were secured against unauthorised access and easy to navigate. The records reviewed were generally legible and of a good quality. They all contained sufficient information regarding the individual recording each contact with the patient, the date of each appointment and the type of treatment given, and any decisions made during each appointment.

However, we found a lack of consistency across patient records regarding the recording of Read codes. Senior staff were informed of this and understood the importance of ensuring consistency.

Quality of Management and Leadership

Governance, Leadership and Accountability

Grange Medical Practice is a partner lead practice and part of the Cardiff City and South cluster group.

We were told that the practice had been under additional strain since a nearby practice closed and all patients were transferred to Grange Medical Practice. We were also informed that the local area was undergoing a huge amount of redevelopment. Staff expressed concerns regarding the construction of additional housing putting even more strain on the practice in the future.

Staff informed us that one of the senior partners was responsible for clinical oversight for the practice and any clinical information is shared during weekly practice meetings. However, our review of meeting minutes highlighted a lack of information being recorded, with some meetings not recorded at all. We informed staff that they must ensure detailed minutes are recorded and made available after all meetings. These should then be filed appropriately.

It was clear from conversations with the practice manager that the practice is proactive in the cluster group in developing future plans. An example given was of conversations being instigated by the practice around the possibility of another cluster surgery closing, thus potentially needing a plan to take in many additional patients.

Whilst reviewing practice policies, we discovered that none of them were dated or contained dates for review. We require senior staff to update all practice policies, ensuring they are dated and contain a date for annual review. We also noted that there was no system in place to evidence that staff had read the policies. The practice manager should implement a sign and date sheet for policies for staff to sign and date once read.

Workforce

During our inspection, we reviewed a selection of six staff files. In the files reviewed of reception staff, there was no evidence that the relevant Disclosure and Barring Service (DBS) checks had been carried out. The practice manager confirmed that DBS checks were not routinely undertaken for any members of the reception team. We raised this as an immediate concern with senior staff. All members of staff without a DBS check must have the relevant checks undertaken immediately. Proof of DBS checks for all staff must then be kept on record by the practice manager.

From our review of staff records, it was also evident that not all staff at the practice could evidence that they had completed and were up to date with mandatory training. This included safeguarding, fire safety, infection prevention and control and CPR training. The practice manager also confirmed that they do not currently have a training matrix in place to track staff mandatory training. This was raised as an immediate concern with the practice. All staff should complete and remain up to date with all mandatory training. Evidence of completion of training must be recorded in staff files. We also informed the practice manager that they should develop a training matrix as soon as possible, to keep track of mandatory staff training.

The practice manager also confirmed that staff had not received equality, diversity, and inclusion training. Staff must complete this training and a record kept in staff files.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns identified			

Appendix B - Immediate improvement plan

Service: Grange Medical Practice

Date of inspection: 16/01/2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Staff must ensure that checks on emergency drugs and equipment are completed and always logged , and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged. All emergency drugs must also be stored securely.	Standards 2.1 / 2.9 Managing Risk and Promoting Health and Safety/ Medical Devices, Equipment and Diagnostic Systems	Nursing Team to carry out a weekly audit and check of the emergency trolley. All equipment/devices to be tested and drugs checked for expiry. These checks to be documented and signed off by nursing team, and checklist retained for 12 months. Emergency drugs will be stored in a tamper-proof bag, with a security break-seal, thereby evidencing if bag has been tampered with if seal is broken. Tamper-proof bag has been ordered and check of drugs will be included in weekly emergency trolley audit.	Sister Christine Roberts Sister Angharad Evans	Immediate Within 7 days (bag on order)

The practice must ensure that pre-employment checks for all staff include the need for a DBS check appropriate to their roles. All current members of staff must have a DBS check undertaken urgently, appropriate to their roles. A record must be kept within the practice.	7.1 Workforce	Reception staff do not have 121 patient contact, and do not chaperone. All clinical staff have DBS checks in place, although some are several years old. NB. A DBS check does not expire and only needs to be repeated if there is a change of role/employment. However, the partners have agreed for the sake of completeness we will repeat DBS checks for all appropriate staff, and also sign up for the automatic update service. Reception staff are also happy to have standard DBS checks carried out where appropriate.	Sam O'Connell (Practice Manager)	In process at present – DBS checks can take up to 6 weeks to be returned from the Umbrella Org that is processing them. All returned DBS checks will be held on site. Clinical DBS checks are being organised via NWSSP
The practice manager must ensure that all clinical staff have received the Hepatitis B vaccination and that evidence of this is recorded in their staff files.	7.1 Workforce	GP Partners and clinical staff have been asked to provide evidence of Hep B vaccination and/or proof of antibody levels as a matter of urgency. If this is not possible to obtain from own GP, then clinical staff will need a blood test to monitor levels and/or repeat Hep B vaccination. Record of Hep B status will then be held centrally at the Practice.	Sam O'Connell (Practice Manager)	Within 30 days

We require All staff to complete and remain up to date with all mandatory training and record evidence of this in staff files. The practice manager must develop a training matrix to effectively keep track of mandatory staff training.	7.1 Workforce	List of mandatory training requested from LHB. Now received. Clinical staff advised to produce copies of certificates for all training. Reception staff already complete and in staff files. BLS training booked for in-house session. Training record matrix created (rather than keeping certificates in individual files) This will be populated over the next 30 days as certificates are supplied and any outstanding training completed. This document will be held centrally on shared drive as a summary of what is contained with HR files, and as an ad-memoire to when training falls due. Ad hoc and role specific training will be added to the training matrix as required.	Sam O'Connell (Practice Manager)	Matrix completed Outstanding training for staff within 1 month. BLS/Resus training scheduled for 22nd Feb onsite.

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): SAM O'CONNELL

Job role: PRACTICE MANAGER

Date: 24/01/2023

Appendix C - Improvement plan

Service: Grange Medical Practice

Date of inspection: 16 January 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Staff should make every effort to ensure patients' preferred language is recorded consistently across patient records.	Standard 3.2 Communicating Effectively	New patient registration process reviewed. Preferred language is an **optional** field for patients to complete. Admin staff who input forms should now treat this field as **mandatory**, and if left blank by patient, contact them to collect this data if patient agrees.	Tracy Stone – Assistant Practice Manager & Reception Manager.	Immediate Action taken – completed 24.02.2023
Staff must ensure they are providing the active offer for Welsh speaking patients.	Standard 3.2 Communicating Effectively	Welsh speaking Dr, Nurse and Pharmacist employed at Practice. Staff reminded about Active Offer. Patient records	Tracy Stone – Assistant Practice Manager & Reception Manager.	Immediate Action taken – completed 24.02.2023.

		annotated if Welsh Language preferred.		
We recommend Welsh speaking staff wear 'Iaith Gwaith badges' so patients can easily identify them.	Standard 3.2 Communicating Effectively	4 x Iaith Gwaith badges ordered from the Welsh language commissioner website	Sam O'Connell – Practice Manager	Immediate Action taken – awaiting delivery
The practice manager must ensure that the following policies are in place as soon as possible: • Consent policy • Triage policy • Equality and diversity policy, • Discrimination policy	Standard 3.4 Information Governance and Communications Technology	Policies currently being drafted before being approved by Partners.	Sam O'Connell – Practice Manager	To be completed and approved by 30 April 2023
Staff must ensure a date is added to the Business continuity Plan and a date for annual review.	Standards 2.1 Managing Risk and Promoting Health and Safety	Issue No. and Annual Review Date added to document as requested	Sam O'Connell – Practice Manager	Completed 01.03.2023

Data shredding stored in clinic rooms and storage rooms currently pose a fire risk. Staff must ensure that bags of shredding are stored securely in outdoor bin area.	Standards 2.1 Managing Risk and Promoting Health and Safety	Have confirmed with building owners that smoke detector and sprinkler system exists to mitigate any paper storage risk, however we have arranged: 1. All shredding with be stored in locked and secure area outside of building. This area is inaccessible to public. 2. Currently data shredding is securely completed on-site by external company – this will be increased to a monthly visit to reduce amount of shredding held on site.	Sam O'Connell – Practice Manager	Completed 01.03.2023
The practice manager must contact the owners of the building to obtain copies of the environmental and health and safety risk assessments.	Standards 2.1 Managing Risk and Promoting Health and Safety	Contact made with PHP Properties Help Desk. Request made for copy of documentation – both historical and for all future assessments	Sam O'Connell/PHP Properties	30.04.2023

We require the practice to carry out both an Infection prevention control, hand hygiene and clinical waste audits as soon as possible.	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Discussion with Nursing Team – agreed responsibilities and planned audits and review. Diarised for regular review.	Nurse Angharad Evans, Christine Roberts, Carmella Greenslade & Tia Thomas	To be completed and appropriately documented by 30 April 2023
We require staff to review the IPC risk assessment and ensure it is kept in date with regular reviews.	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Discussed with Nursing Team – agreed responsibilities and review. Diarised for regular review.	Nurses Angharad Evans, Christine Roberts, Carmella Greenslade & Tia Thomas	To be completed and appropriately documented by 30 April 2023
Staff must ensure the safeguarding policy is updated to include details of the current Safeguarding lead at the practice and contains information specific to Wales.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	Identified omission from policy. Documents & File updated	Sam O'Connell – Practice Manager	Immediate Action taken – completed 24.02.2023.
Staff must ensure they have access to the current All Wales safeguarding guidance. We recommended all staff access the All-Wales Safeguarding phone app.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	All Practitioners have downloaded All Wales Safe-Guarding phone App.	Dr Seema Sinha, Dr Jane Fryer, Dr Jane Roberts, Dr Ian Lane, Dr Meg Evans, Dr Sophie Hough, Dr Steve Harris, Dr Sally Williams	Immediate Action taken – completed 24.02.2023.

Staff should ensure all yellow clinical bins are kept locked, even whilst in locked rooms.	Standards 2.1 / 2.9 Managing Risk and Promoting Health and Safety/ Medical Devices, Equipment and Diagnostic Systems	Nursing Team & Cleaning Team reminded of the need to secure the yellow clinical waste bins held in the disposal hold. Identified that the weekly clinical waste collection is enough, but we may need a further large clinical waste storage container if we continue to generate excessive clinical waste. Nursing team to monitor over next 3 months.	Nurses Angharad Evans, Christine Roberts, Carmella Greenslade & Tia Thomas	Immediate Action taken – completed 24.02.2023. Review of need for additional storage to be revisited on 30.04.2023
All staff must be aware of the process in place to remove flags from patient records, indicating a potential child at risk.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	Process demonstrated and noted by all clinicians	Dr Seema Sinha, Dr Jane Fryer, Dr Jane Roberts, Dr Ian Lane, Dr Meg Evans, Dr Sophie Hough, Dr Steve Harris, Dr Sally Williams	Immediate Action taken – completed 24.02.2023.
Staff should ensure detailed minutes are recorded in all staff meeting. These should then be filed appropriately and made	Standard 3.4 Information Governance and	Practice Meetings are undertaken every Wednesday AM 8.30-9.30. Minutes are now taken during the meeting and	Sam O'Connell – Practice Manager	Immediate Action taken – completed 24.02.2023.

available for any staff unable to attend the meeting.	Communications Technology	distributed to all staff via email immediately afterwards.		
The practice must ensure that there is consistency in recording Read codes in patient records.	Standard 3.5 Record Keeping	Currently undertaking a review of read coding across the Practice. Analysis of any differences being reviewed with a view to attaining consistency.	Dr Ian Lane – GP Partner Ravi Srivastava – IT & Development Manager	Review by 30.04.2023 Action by 30.06.2023
Senior staff must update all practice policies, ensuring they are dated and contain a date for annual review. We also recommended that the practice manager implement a sign and date sheet for policies, so staff can sign and date once read.	Standard 3.4 Information Governance and Communications Technology	All Practice policies amended with Issue Number, Date of Issue and Review Date. Also contains staff signature sheet.	Sam O'Connell – Practice Manager	Immediate Action taken – completed 24.02.2023.
All staff must complete equality, diversity, and inclusion training as soon as possible. Evidence of completed training should be kept in staff files and on record by the practice manager.	Standard 7.1 Workforce	Suitable training programme to be identified – support and advice sought from UHB PCIC team. All staff to complete this training and records included in their training records/training matrix.	Sam O'Connell – Practice Manager	To be completed by 30.06.2023

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): SAM O'CONNELL

Job role: PRACTICE MANAGER

Date: 16/03/2023